

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
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9:00 a.m.

COMMISSIONERS PRESENT:

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MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Using information on quality in Medicare
-- Karen Milgate, Nancy Ray

MR. HACKBARTH: Next up is using information on quality.

MS. MILGATE: So now we're going back up to the 20,000-foot level, I believe, so adjust your minds. In this session what we're going to be discussing is a proposed workplan for the upcoming year on the subject of using information on quality in the Medicare program. What we'd like from you today is feedback on the general direction and specific goals that you found in the outline we provided for you as background material, but wanted to suggest that this is an introduction really to a more detailed discussion at the summer retreat. So you'll have a second stab at this and presumably we'll be able to provide you with even more detailed materials before the summer retreat to discuss.

Medicare is responsible for ensuring access to high quality care, yet we know little about the product that Medicare purchases for so many beneficiaries. We know what services are bought, where they are delivered, how we pay for them, and how much the program spends. However, we know little about how safe they are, how effective the care delivered is, how timely they are, or much about what beneficiaries or their families think about the manner in which the services are delivered.

So why does Medicare need information on quality? How would they in fact meet that goal of ensuring access to high quality care? First, Medicare needs information on quality because it's their responsibility to assess the value of the care that's purchased. In this aspect of measuring quality it really helps the program identify problem areas and helps them identify ways to seek ways to actually improve care overall.

We do have some information in the aggregate that's already used for this. For example, the QIO program indicators that look at hospital care and some indicators of ambulatory care. They have aggregate data, for example, on how many Medicare beneficiaries across the country actually get beta blockers after AMI in the hospital. Then there's 26 other indicators in fact which we have information on what beneficiaries are and aren't getting which is appropriate care.

Another way to actually use information to assess value would be, for example, to identify diabetics that are in the program and then look at the types of services they get to see if in fact they're getting the right services at the right time.

As I said before, we're beginning to have some information in some settings to assess value. However, we don't have that information in all settings and it's unclear whether the information we have is in fact what we really want for this purpose.

The second purpose for Medicare needing information on quality is to evaluate payment adequacy, which is clearly a goal that's near and dear to the hearts of the folks on this commission. We do use some information to evaluate payment adequacy. One indirect measure is the financial health of an

institution, for example. Whether in fact the institution has the ability to delivery quality care is in some ways related to whether they are financially healthy or not.

Another measure that we use, in particular in the dialysis world, is whether quality is improving over time. So we do have some information on that. However, we need this type of information in more settings. We don't have whether quality is improving over time in all settings. In fact one could suggest that we might want to use additional measures to evaluate payment adequacy. For example, the occurrence of adverse events over time might be one to look at, or in post-acute settings there have been some research to show that there may be case mix changes over time depending upon payment levels.

The third reason Medicare needs information on quality is to distinguish among providers. In fact there are several purposes for distinguishing among providers. The four that we've identified are, one, to inform consumer choice. Two, to stimulate provider improvement. Three, to focus surveyor efforts. And four, to reward high quality. Whether we think the information that was provided in the full-page ads yesterday in fact was the most useful information, the goal of this information I would say would be all four of those in many ways. So it's an example of CMS trying to actually find a way to distinguish among providers.

However, once again we don't have this information in all settings. We have the ability to distinguish on some measures between dialysis facilities, some measures for nursing homes, but there are many other settings in fact where CMS doesn't have this information. Then there's also questions about whether the information that the Medicare program does have is the most useful information in fact for distinguishing among providers.

One of the most important things to look at in this area is how valid or reliable the information is that's able to be collected and used in various settings of care.

The goals of the proposed analysis are three. First, to evaluate Medicare's strategies for measuring and using information on quality. Then falling out of that evaluation, to potential recommend ways to improve the collection and uses of information on quality. We also believe the analysis could help lay groundwork for future work on the interaction between quality and payment.

The last slide here just describes a proposed workplan. We think there's basically three steps involved. Each step is designed to answer a different question and they're sequential steps. The first question would be, what do we know about quality and quality measures? So in this step what we would need to do is get a sense of what we already have. What do we know about quality? What types of measures are out there?

We would presume to do this analysis based on various settings, and we would include the providers in the Medicare fee-for-service program and also the M+C plans, which of course in the report we just issued we had a lot of analysis there on what's already collected on Medicare+Choice plans.

Then from that step, when we get a sense of what information

we do have, try to identify gaps in what we may in fact want to know beyond the information we have. Find out if the information is sufficient in fact to assess value, to ensure payment adequacy, or to distinguish between providers. Then if not, and we do identify gaps, would we in fact be able to get that information from better analysis of data we already have?

For example, what's the capacity of administrative data? Have we reached that capacity in terms of what we might be able to glean from that on quality? Or are there other types of information that we may need to collect from providers or plans? If so, are there other ways to get it? For example, could we get some information from private accreditors rather than requiring direct collection from providers or plans?

So that concludes the formal presentation. I hope it's given you a sense of what we're talking about. We'll be glad to hear comments and, of course, any questions you might have.

MR. HACKBARTH: Based on things that we've said previously it seems to me that there's no disagreement about the premise of the absence of quality information. We've said in various places it's a major problem, not just for the Medicare program but for the health care system in general. So from my perspective the questions here are, what can we contribute within the available resources we've got to move the ball forward? Are there efforts of other groups that we need to know about or maybe piggyback on that would give our efforts here some more impact?

DR. BRAUN: Apropos of what Glenn just said, I noticed that the National Quality Forum was not mentioned and that certainly is one group that's working on quality and I would think that would be helpful in this situation.

The other thing that comes to my mind is, we need a lot more emphasis on information technology. We think about all the things that can be done to move toward quality, but until we really put enough investment in information technology we really can't do it.

MS. MILGATE: Could I say something to your point, Glenn and Bea's?

MR. HACKBARTH: Sure.

MS. MILGATE: What we would assume and the first step I suggested in the workplan is in fact that we would go beyond what CMS has and look at what's out there at accreditors, at the state level, employers, in a similar way that we did with the quality improvement report where we looked at the standards that a lot of different entities use. We would then turn our attention more to the information they gather on actual quality measures. So we wouldn't assume to develop all of this at all ourselves, but more to look at what's out there and then take a look at what we have and whether we might want to use some of that information.

MR. HACKBARTH: Maybe I can articulate my concern a little more clearly. I view this as an investment decision. We've got limited resources and we need to use them in a way that we get the maximum return possible. This is certainly a critical issue.

It's not clear to me what we're talking about right now in terms of investment, and I suspect it's not clear to you either. Are we talking about this is the focus of the next June report or

are we talking something substantially smaller than that? I don't mean for this to sound as criticism, it's just a question I have about how far we go down this track and whether we're going to get a return on our investment. I'm very open to it. In fact I'm delighted that you're bringing it here, but I think we need to get a handle on how much we're going to invest in it.

MR. FEEZOR: I think it's a worthy topic. I guess, Glenn, I'm sharing a little bit of your concern about trying to pare it down or at least put it in a couple different buckets that may help it solidify, if there an ROI, if you will. The one that I get, we tend to -- and I notice we use the terminology throughout several of our reports where we talk about the Medicare program buying. I would argue that the Medicare program pays for. That the purchasing and the buying is done largely by the beneficiary.

It's in that construct or that division that it may be helpful to think about quality measure. One would be quality measures that in fact help enable the purchasing decision, which is largely that of the individual. That may be the quality of the provider, or the value of one Medicare+Choice versus another.

The second is in fact those quality measures that really verify the value of the payment. That in fact we are getting what we paid for. That perhaps is more what the Medicare program is interested in. It may be that looking at it in those two ways may help us say, first off whether we'd like to contribute, and probably more narrowly constructed it's in that latter category that we'd have program, I guess, responsibilities. So that's some thoughts.

DR. WAKEFIELD: Actually I'm taking a little bit of a broader view, maybe the 25,000-foot view instead of the 20,000 we kicked off with here. My sense is what we're all -- what we're doing right now is just putting some ideas on the table that will be fleshed out in much greater detail and with more precision and focus at the retreat. So mine are a broad picture perspective.

One, I think one might think about starting off this discussion and grounding it a little bit, I'm always an advocate for the Quality Chasm report so I'm putting it out there again. But to the extent that in that report some of the discussion is about aims for improvement I don't think that's a bad place to start frankly.

One of the recommendations was suggesting that public purchasers, for example, ought to think about the application of those aims. They are the care for, in this context, Medicare beneficiaries would be safe, that it's effective. That is, that it's based on the best scientific knowledge so we're not driving overuse and underuse. That the care is patient centered so it's responsive to Medicare beneficiaries' preferences and values. When it can be, that it's timely. That it's efficient. That we're not wasting resources, money, technology, et cetera. And that it's equitable. That the quality doesn't vary because of where somebody is getting it, or by gender, or by a Medicare beneficiary's socioeconomic status, or whatever.

So stepping back, big picture, I don't think that it would be a bad idea to think about whether or not, at least as a backdrop to this discussion one might think about starting there.

I think from my perspective a fundamental question for us is, can we get better quality? Can we work toward improving the quality of care that Medicare beneficiaries get? That's quality improvement, that is a little bit separate from quality assurance. We've talked about both of those historically. I thought this discussion was a little bit more slanted toward QA, but you do have improvement there. So I'd want to make sure that we're covering both of those bases in a document.

I also think that a lot of attention on the extent to which one could align financial methods to decrease care fragmentation would be a good thing to think about. So really looking at the issues that you've raised a little bit thus far, looking at quality related to payment policy. And can our payment methods, can we look at them to ensure at least that they're not putting barriers up, where that can be identified, to providers attempting to provide good quality care.

For example, even the discussion we had a couple of minutes ago, Ralph's comments, and I'm going to take them -- if you suggest I'm taking them out of context you can comment, certainly make that comment. But Ralph's comments earlier about long term care facilities and acute care facilities and patient transfers between those two entities and that if we had seamless -- if we had payment policies that were structured to facilitate seamless continuity of care, for example.

So could we be looking at the extent to which some of our payment policies may or may not be facilitating quality improvement, actually might be serving as barriers to high quality care, at least with that notion in mind.

Also, I'd keep an eye on coordination of care. We talked a little bit about that yesterday in different context but I went back this morning and pulled one page from one of the documents that we're looking at that mentioned that, for example, the average beneficiary with one or more chronic conditions was seen by eight different physicians during 1999 according to one study, and had 17 to 24 prescriptions filled in 1998. My God, if those stats don't beg for coordination of care across eight different providers, it certainly asks the question, I think, are patients -- is that care being coordinated in a way that it should be, et cetera?

So some of the discussions that we had about care management and disease management yesterday, and how can we, with financial incentives, et cetera, or demonstration programs, or strengthening the demos that CMS currently has underway, just to try and think about that, given the nature of the beneficiary population that we're dealing with. So I think quality is just a terrifically important focus.

Last point. With regard to looking at -- or two last points. One, to the extent we can think about engaging Medicare beneficiaries themselves and their response in terms of the usefulness of information, other vehicles for disseminating information, is a finer point that we can put on some of these embryonic efforts to push information out to the Medicare population like the newspaper ads that we're seeing so far? Is there a way that we can engage beneficiaries themselves a little

bit more fully?

And in terms of drawing on other resources, just a comment that early next year AHRQ, as you know, has been asked to produce for Congress and the Administration its first report on quality, a national perspective on quality of health care in America. There might be, as they're developing that there may well be some things that we could draw on here that could inform our thinking as they're doing their work.

I would suggest they've put tremendous amount of resources already in the last six months into the development of their data collection structure, and how they're thinking about capturing that information. Why reinvent the wheel? I think some conversations with those folks about how they're moving and what we might be able to capture from that would be appropriate.

MS. MILGATE: Mary, all the discussion of the ideas you have about what to look at in my mind would fit in the second step of, first we'd see what we know and then say, okay, do we have enough, for example, to look at care across settings? So your discussion is exciting to me because that's exactly the more detailed discussion that I'd like us to have in the second step of the process.

Just on the IOM comment in terms of starting there, one other thought we've had is to start with the IOM components of quality as one way of analyzing also what information we have. What information do we have on effectiveness? What information do we have on safety? Is it enough? Do we want more?

DR. WAKEFIELD: That's really Bea's comment about information technology.

MS. MILGATE: Yes.

MS. RAPHAEL: I guess my view is, I don't think we need to produce another report on quality. I think we really need to clarify our focus and what we're going to contribute. I think there are two areas where we could contribute, and some of this is building on what has been said already.

I think the first issue for me is the relationship between quality and payment policy because ultimately quality is determined by what happens at the practitioner encounter level, whatever that encounter is. I can tell you that my greatest challenge is taking evidence-based knowledge and having that translated to what happens every day out in the field. That is the challenge.

I don't want any more evidence-based knowledge right now actually. I have more than enough. I have to really focus on the application and the translation. If there were some way that payment policy could help in stimulating that, I think that would be significant. Also, if there are techniques or demonstrations of how other systems have done this I could really benefit from that knowledge base.

The other thing, I do agree with Mary that wherever payments can facilitate the transitions, not just looking at quality in one setting but really the trajectory of care across settings, I think that also would be a contribution.

Secondly, I'm going to take a very minority position here, but I would like to better understand the relationship between

information and quality. There is an assumption that if you have more information you have more quality. I really believe you need just-in-time information. Someone recently told me he sat - he worked with the National Quality Forum and he said, I've done all this work for two years with the National Quality Forum. I had a serious illness. He said, did I look at any of the information that I gathered? No. I called up a friend and I said, what should I do and where should I go?

I think to me that is something that we need to tackle because just to create more and more information to me is not going to really move that ball down the field of quality. So if we could really tackle that whole issue on how to get people useful, just-in-time information, or really work through the way people make decisions, that would be useful.

Lastly, I think when we have this view of quality as totally focused on patient safety and errors, I think that's too narrow, because I think part of the issue on quality that I grapple with has to do with not intervening in time, not identifying a problem and not moving to deal with the problem. In some cases you could say it's neglecting the situation.

But I think a very key component of quality has to do with that sort of problem identification rescue and moving to deal with it. It's beyond just making an error. It's a system of care, a process of care. I think that to me, particularly in the post-acute setting, perhaps as well in acute, and even with physicians, it's something that has to be part of how we're looking at the quality equation.

MR. MULLER: Like Carol, I feel we don't need to do one more macro quality study, but I would suggest at least three areas where we could be helpful. One is to get a sense of where we spend the money, Medicare spends money on quality efforts right now.

I know for many of us who come from institutional settings, if I had to think about where the most considerable expenditure of resources are towards quality, both assurance and improvement, they are in fact in traditional functions of complying with state regulatory codes, Joint Commission, liability reduction efforts and so forth. So there's money, and I wouldn't say it's 5 percent of the total resources but it's more than a trivial amount of resources that gets spent in those ways, probably far more than trying to do the things that the Quality Forum and so forth are suggesting.

So there's a considerable -- so I think whether one does it through cost reports or surveys and so forth, getting some sense -- and maybe this is by Mary's definition old-fashioned quality efforts, but I think if you look at where the resources are being spent on quality enhancement efforts right now it would be good sense, and maybe those become targets for redirection in ways people would want us to redirect. So one is just get a sense of what we're spending on quality broadly defined right now.

Secondly, to build on Carol's point is the question -- in many ways I think the quality of the Medicare program is driven by payment policy. Now we had a lot of discussions both this year and in many years prior to that as to how payment policy

affects quality. I think we probably more than other players inside the system are equipped to talk to the issue of how payment policy affects quality because I think that's our natural bent. And I think there's a lot of effects on quality as to how -- just going back to the discussion we just had on long term care hospitals.

So I think the interrelationship between payment policy and quality I think is where we have a natural advantage in contributing to this conversation.

The third point I would make is thinking about the role of the national system versus a more decentralized and local system. Again going back to my first point, a lot of efforts at quality control are localized; the state health departments regulate almost all the providers inside the system that we're talking about.

Again going back to my recent examples, having seen a government over in England try to do this now from the point of view a national setting in terms of quality control and have very tight control from the center of quality measurement versus the more decentralized model we have here, I think at least to me it's informed my thinking about that.

I don't think, despite what ads CMS is putting in the Washington Post and Denver Post that we're likely to go through a national quality measurement system any time soon. Yet many people talk as if we're going to move towards that kind of a system.

So a third thing I would look at is the question of how much of this can in fact be done centrally as a kind of national level quality measurement effort versus building on all the other parts we have inside the system right now.

I would argue that, going back to my first point, there's a lot of expenditure of resources being spent on quality measurement around the country right now. Perhaps not as well as many people would like to have done, but there is the most significant effort right now in terms of expenditure of resources is on a very decentralized basis. So I think it makes sense to take that into account and try to measure that, and then perhaps speak a little bit then to what that balance might be.

If I could just, if I made up a number and said, if 80, 90 percent of the expenditure of resources were really decentralized -- and I don't know if that's the number. I'm just using that for the purpose of argument. That would tell you something about how much you would move towards a national quality control measurement system if in fact 80, 90 percent was being spent in a very decentralized basis right now.

So I think, again, very much tied, to summarize, tied to where is the quality, where is the expenditure of resources right now? And very specifically I would like, since I feel strongly that what Medicare most does to affect quality is its payment policy I think that's a natural place for us to speak somewhat knowingly about it.

MR. SMITH: I'm always happy to follow Carol in the queue because she helps me clarify what's on my mind. I would really focus I think, Karen, on the second point that Carol made.

There's an enormous amount of quality information out there. There are certainly holes in it and step two is important to try to identify those. But my guess is that it would be very important to focus on how effectively the providers, payers, and purchasers consume that information. Do they have access to it in an effective way? Do they consume it in an intelligent way?

The existence of the information doesn't mean that it's well utilized by any of those three players. I suspect Carol's example of her friend is more typical of all of us in our purchaser role and not surprisingly it probably affects Medicare in its payer role.

So I'd like us to take a look at the consumption and the barriers to effective consumption of the information that we already have as well as thinking about where there may be holes in the data itself. But Carol's second point it seems to me is central to making sense out of this.

DR. LOOP: Let me give you some points that you might want to discuss on the retreat. One, if you take too broad a view you're liable to come up with nothing. So in terms of hospital quality you might consider starting with the top 10 to 20 DRGs, since that's the highest volume.

The second point, in clinical medicine surgery is a lot easier to measure than medical outcomes.

A third point is that the real outcomes are often far removed from the site of diagnosis and treatment, and that requires follow-up, and that requires a lot of money.

I think you're wise to start somewhere, and I think the IOM report is a good one. You have to decide whether you're going to push evidence-based medicine as a part of the quality outline.

The other point that I have is that if we could figure out how to decrease the regulatory burden we might actually improve quality.

Last, I believe that quality begins with assessment by the individual provider, and that hospitals in particular should be encouraged to assess and ensure quality as their top priority.

MR. DeBUSK: I want to make a comment about the second bullet point there and David referred to. The second part of that is, is the information used by Medicare adequate? It's certainly not JIT. If anything it's historical and probably should be archived. But the absence of proper information as it relates to quality is certainly missing.

Now how can we get, how can we look forward and access that information, regardless of where it comes from and be more JIT in the way we function and we make decisions? That affects everything.

And our data, we talked about it many, many times, is inadequate. I was glad to see it come up in bullet point two. I think this is something, if we want to improve quality and whatever aspect we're talking about, we're going to have to get better data. We always talk around this. Now I know it's complex and I certainly don't have the answer but out there somewhere is the answer to us getting better data. That's where we should be spending our money. If you were in business in the private sector you'd sure go broke fast if you didn't have that.

MS. BURKE: Having listened to everyone's list of what we might do and why we might do it, I am struggling to understand, given your opening comment about limited assets and limited resources, how many of these things are in fact within our purview, how many of them we can actually have value added in terms of content, and the order in which those things make sense. I'm not disputing the value of any of the things that people have discussed, but I am questioning our capacity to do them all.

The goals of the analysis as articulated in the document that look at the effectiveness of the current strategies and try and understand ways to improve how we collect and use information, and then further how we use that in terms of the linkage to payment I think can either be expanded to cover the universe or can be narrowed to something that is doable. I guess my only cautionary note is, and perhaps this is best done at the retreat, is that before we start down a road that would have us literally consumed over the next 10 years in looking at every single issue related to quality, that we look at where we can add value, and what it is that is doable in a reasonable time frame.

I think the issues around what it is Medicare is doing currently and how it is spending its money with respect to quality is quite an important one. I think questions ultimately about how we link specific expectations of behavior or output in order to link it to payment, it's critically important for our purposes in terms of how we structure payment systems. The use of information is obviously important. How consumers use it is obviously important.

It's not clear to me that is where we can do the most work in terms of value added; not questioning the value of that work. It's not clear to me that for our purposes that's what we might best do.

So I would just ask that we try and narrow down to something that is doable and reasonable. Some of it is looking at work that has already been done by others, which I think makes a lot of sense, and obviously you are tuned in to already begin to do. But I think there are a whole series of questions out there that everybody is struggling with.

I think Carol is right on, that there are practical questions that must be dealt with. It's not clear to me we are capable, nor should we do all of them. But there are some that are specific to Medicare, just getting a handle on what it is they're doing today and how much money is being spent.

The whole issue of regulatory burden is quite an appropriate one. The claim and cry that you hear from many providers and organizations is that the magnitude of the demands on data from a variety of sources that require them to constantly duplicate efforts, or produce information in a different way for different purposes to be used for presumably the same reason, there are a lot of issues like that that are quite legitimate.

Again it's not clear to me we can answer all those questions. So I guess I would simply hope, I think everyone is committed to quality. I think going forward with some attempt to try and understand what it is that we can be doing and what Medicare is doing is appropriate. But I would hope we refine

that a little bit rather than add to the list of things that need to be done. Perhaps that's best done in the retreat, but I think I'd just -- I'm having trouble getting my arms around what literally you're being tasked to do other than the universe of quality.

MS. MILGATE: The logic in my head at least, and this really is just my head I guess at this point. Let me just throw that out there -- is that this would be a first step to some of the other things that people were saying was important in how you would use information. We didn't have enough of a sense in our heads about what we actually knew in various settings to even know what we might want to know.

But I guess what I'm hearing back from some Commission members is a sense that we may want to go more directly to the question of the relationship between using the information rather than just more of a passive look at what's out there. Let me just throw that out.

MS. BURKE: I'm not sure that, at least from my perspective I'm not sure that's what I meant; that is to go directly to the what. I think it's really to try and understand, what do we need to know, to what end? That will hopefully guide us in where you can best target your efforts.

Obviously, linkages to financing is a critical issue for us because of the way we create expectations in payment policy. Equity between sites of care, what are our expectations? The publication of the list yesterday raises the point, all right, are there similar expectations with individual providers? Are there expectations with large institutional acute care facilities? Getting some sense of what those linkages are.

But again, I'm just struggling to understand how best to task you so that it's targeted to the things that we need to do.

MS. MILGATE: In terms of resources, just to be clear, we weren't anticipating this be a stand-alone big report like the quality improvement report. We would hope to have some information that's already out there gathered by CMS to include an aggregate summary perhaps as part of the description of how settings are doing in the March report. But then also possibly in a June report as a chapter, identify information needs for quality. There's been some discussion of perhaps doing a report next year on information needs of the program and that this would just be one segment of that. Just it wouldn't be anticipated that

-- because obviously could be huge.

MR. HACKBARTH: This probably seems a bit of a downer to you, the response that you're getting. But I'd emphasize the positive here. I think there is unanimous agreement that the broad issue area is important, but also a fair degree of unanimity that it's so broad that we could easily get lost in it.

One of the things that I've been learning this past year as chairman is that, and I get most concerned when we take on these really broad topics because we've got not only finite staff resources but we've just got a limited amount of time together. We can only process so much as a commission as a group. When we tackle the very big topics, regulatory burden or the benefits

project, those are the times that I worry, are we making a contribution or not?

So I'd like for us to have, before we take things on and make that big investment, pretty clear ideas of where we can offer something unique. So that's the question. What I'd ask is that you and Nancy come back at the retreat, having heard some ideas about what the handles might be, and see if you can help focus us in some compelling areas.

DR. NELSON: I raised my hand also to make an appeal to not try and redo the Chasm report, to be more narrow. I think that the question we ought to address is what expectations, what reasonable expectations should Medicare have as a purchaser for quality demonstration. GTE has certain expectations, the Leapfrog group has expectations.

If computerized order entry is the key to error reduction, should the Medicare program, should we recommend that the Medicare program by some point certain in the future insist on computerized order entry as part of conditions of participation? Right now the main quality expectations are centered around the conditions of participation. That clearly isn't going to be -- that plus the requirements for Medicare+Choice. That clearly shouldn't be the way this program goes.

Business is way ahead of us in demanding certain deliverables with respect to quality. I think that we should focus on what those kind of deliverables for Medicare might reasonably be, taking into account the need to balance with the administrative burden. You can't require performance measurement on all of these office-based practitioners who are keeping a paper record; you know, how many of your diabetics had their feet examined, because you can't retrieve those data without just an enormous burden. But there are things that can be done.

DR. STOWERS: To me, I think we need to narrow it down to a couple questions: how is current payment policy affecting quality? Then how could it be changed to improve quality? To me this is like looking at ethics in a medical school curriculum; do you teach it in an isolated class or do you integrate it through the whole curriculum? I think it would be good here maybe to do an overview report or an idea of where we're headed on this.

But I think something that would be very valuable to everybody would be, whether we talk long term care facilities or home health care or physician payments, that in every one of those chapters from here on out we ask ourselves those two questions and start integrating it into each report on an ongoing basis; hospital updates, whatever. And not just look at a single report but start integrating it more into all of our reports and working it in that way.

I think in the long run we're going to be more valuable that way than trying to come up with one more giant report on quality. But every time we deal with those updates we bring that into the discussion.

MR. HACKBARTH: Any final questions?

MS. MILGATE: No. I think that's useful feedback.